

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, place the certificate in the "pending" file in the General Director's Office. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 7/59

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FOR STATE
HEALTH DEPT.

7944
MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
09046

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Dorchester		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 13 Cambridge		
c. LENGTH OF STAY IN 1b Life			d. STREET ADDRESS 140 Douglas St.		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge Maryland Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Gretha Wilson Adams			4. DATE OF DEATH Month Day Year July 21 19 60		
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Dec. 8, 1917		9. AGE (In years last birth day) 42 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles E. Wilson		14. MOTHER'S MAIDEN NAME Lillie Mae Mollock	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 213-22-4762		17. INFORMANT Address Eldridge Adams 40 Douglas St. Camb.Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest under general anaesthesia DUE TO (b) Abdominal operation for cholelithiasis and fibroid uterus. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 954X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Sod. pentothal, anectine, Nitrous oxide and oxygen. Died on operating table.			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 10.30 a.m. 7-21/60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital	
20f. (City or town) Cambridge		20g. (County) Dor.		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John Mace Jr.		M.D. John Mace Jr. M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John Mace Jr. M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/24/60		22c. NAME OF CEMETERY OR CREMATORY Waugh Cemetery	
22d. LOCATION (City, town, or country) Cambridge, Dor. Md.		22e. REC'D BY REGISTRAR Aug 16 '60		22f. REGISTRAR'S SIGNATURE Arthur L. Kline	
23. FUNERAL DIRECTOR Herbert StClair		ADDRESS Cambridge, Md.		24. REGISTRAR'S SIGNATURE Arthur L. Kline	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

7955 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07927

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WICOMICO ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE				c. LENGTH OF STAY IN 1b 4 YEARS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTERN SHORE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last LILLIAN NELLIE ADENT				4. DATE OF DEATH Month Day Year JULY 2, 1960			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 1, 1911	
9. AGE (In years last birthday) yrs. 49		10. UNDER 1 YEAR Months Days		11. UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ILLINOIS	
13. FATHER'S NAME PETER ADENT				14. MOTHER'S MAIDEN NAME KATHERINE SLAYINSKY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 357-14-2203		17. INFORMANT Address HOSPITAL RECORD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA OF THE UTERUS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERAL METASTASES DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JUNE 1, 1957 to JULY 2, 1960 , that (I) (we) last saw the deceased alive on JULY 2, 1960 , and that death occurred at 7:08 P. M. from the causes and on the date stated above.							
22a. SIGNATURE Ettore De Filippis				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED JULY 2, 1960	
22c. PHYSICIAN'S NAME (Type) ETTORE DE FILIPPIS				22d. ADDRESS EASTERN SHORE STATE HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/7/60		23c. NAME OF CEMETERY OR CREMATORY St. Casimir Cemetery		23d. LOCATION (City, town, or county) (State) Worth, Illinois	
24. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Md.				25a. REC'D BY REGISTRAR DATE JUL 8 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07928

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>			
c. LENGTH OF STAY IN 1b <u>40 yrs.</u>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>154 Washington Street</u>				d. STREET ADDRESS <u>154 Washington Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>(Will)</u> Last <u>E. Banks</u>				4. DATE OF DEATH Month <u>July</u> Day <u>11</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 25, 1893</u>		9. AGE (In years last birthday) <u>66</u> yrs.	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Food-Packing</u>		11. BIRTHPLACE (State or foreign country) <u>Alexandria, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Banks, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Clara Banks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW I 217-10-8062</u>		17. INFORMANT <u>Lillie Banks, Cambridge, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiac Decompensation</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>June 1, 1959</u> , to <u>July 11, 1960</u> , that I last saw the deceased alive on <u>July 11, 1960</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>227 Pine St-Cambridge, Md.</u> DATE SIGNED <u>7-14-60</u> ACTUAL SIGNATURE <u>J. Edwin Fassett</u> M.D. PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/14/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nelson M. St. Lawrence</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 22 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

7948

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07929

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dor.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>6 mo.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Elliotts</u>	
3. NAME OF DECEASED (Type or print) <u>Pauline</u> First <u>Ewell</u> Middle <u>Dayton</u> Last		4. DATE OF DEATH <u>7/23</u> 19 <u>60</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/25/1905</u> 34 yrs.
9. AGE (In years last birthday)		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Swain Ewell</u>		14. MOTHER'S MAIDEN NAME <u>Nona Gray</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Austin Dayton, Elliotts, Md.</u>		18. CAUSE OF DEATH [Enter only one cause for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> DUE TO <u>Carcinoma Breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>2 yrs</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/10</u> 19 <u>58</u> to <u>7/23</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>7/23</u> 19 <u>60</u> and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>W. H. Hanks M.D.</u>		22b. DATE SIGNED <u>7/25/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. H. HANKS M.D.</u>		22d. ADDRESS <u>CAMBRIDGE MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/25/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Elliotts</u>		23d. LOCATION (City, town, or county) (State) <u>Elliotts Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Hillyer, East New Market, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 1 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>			

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CERTIFICATE OF DEATH

[Faint, illegible handwriting throughout the form, likely bleed-through from the reverse side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

7960

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07930

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 5 yr. 5 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		d. STREET ADDRESS -	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Marie Middle Grace Last Dickson		4. DATE OF DEATH Month July Day 18 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-11-11
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Handy Hadder, Maryland		14. MOTHER'S MAIDEN NAME Addie Kelly, Maryland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) - (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -	
17. INFORMANT Eastern Shore State Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO 493X Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) - DUE TO (c) - PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) - INTERVAL BETWEEN ONSET AND DEATH 16 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-1-59 to 7-18 19 60 , that (I) (we) last saw the deceased alive on 7-18 19 60 , and that death occurred at 1:15 P.M. from the causes and on the date stated above.			
22a. SIGNATURE George H. Longley		22b. DATE SIGNED 7-18-60	
22c. PHYSICIAN'S NAME (Type) George H. Longley, M.D.		22d. ADDRESS Eastern Shore State Hospital Cambridge, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/21/60	
23c. NAME OF CEMETERY OR CREMATORY EVERGREEN		23d. LOCATION (City, town, or county) (State) BERLIN MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Anna A. Burbage		25a. REC'D BY REGISTRAR JUL 22 '60	
ADDRESS Berlin Md		25b. REGISTRAR'S SIGNATURE Arthur S. Harris	

7860

CERTIFICATE OF DEATH

Deceased

Married

Age 30

Male

Place of Birth

Age 30

Male

Age 30

Age 30

Male

Age 30

Age 30

Male

Age 30

Age 30

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Age 30

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Age 30

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07931

1. PLACE OF DEATH o. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock - Rural		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Petersburg		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle Lester Last Dixon		4. DATE OF DEATH Month July Day 2 Year 1960	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH April 17, 1907
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Dixon		14. MOTHER'S MAIDEN NAME Nettie J. Robinson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Nettie J. Dixon, Hurlock, Maryland, R.F.D.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 0 DUE TO (c) 1 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 0 INTERVAL BETWEEN ONSET AND DEATH 2hrs			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John Mace Jr.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED Jul 2, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 6, 1960	
22c. NAME OF CEMETERY OR CREMATORY Petersburg Cemetery		22d. LOCATION (City, town, or county) (State) Near Hurlock, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR JUL 5 '60 DATE	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

8/10/60

mhb

Thos

1. PLACE OF DEATH																																																																																									
o. COUNTY																																																																																									
Dorchester					MARYLAND																																																																																				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					c. LENGTH OF STAY IN 1b																																																																																				
Hurlock RFD																																																																																									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>																																																																																				
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)																																																																																									
o. STATE					b. COUNTY																																																																																				
Maryland					Dorchester																																																																																				
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)																																																																																									
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4. DATE OF DEATH																																																																																									
First					Month					Day					Year																																																																										
Charles					Millburn					Fletcher, Jr.					July					8					19					60																																																											
5. SEX										6. COLOR OR RACE										7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										8. DATE OF BIRTH										9. AGE (In years lost birthday) — yrs.										IF UNDER 1 YEAR Months — Days —										IF UNDER 24 HRS. Hours — Min. —																													
Male										colored																				7-8-60																																																											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)										10b. KIND OF BUSINESS OR INDUSTRY										11. BIRTHPLACE (State or foreign country)										12. CITIZEN OF WHAT COUNTRY?																																																											
																				Hurlock, Maryland																																																																					
13. FATHER'S NAME										14. MOTHER'S MAIDEN NAME																																																																															
Charles Millburn Fletcher										Alice LaRue Fletcher																																																																															
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)										16. SOCIAL SECURITY NO.										17. INFORMANT										Address																																																											
																				Mr. Charles Fletcher, Hurlock - RFD, Md.																																																																					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH																																																																															
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										Prematurity																																																																															
776X										DUE TO																																																																															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										(b)																																																																															
										DUE TO																																																																															
										(c)																																																																															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																																																															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																																																																															
20c. TIME OF INJURY Month, Day, Year										20d. INJURY OCCURRED										20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town)										(County)										(State)																																							
Hour a. m. — p. m. — 19										While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>																																																																															
21. I certify that (I) (this hospital) attended the deceased from July 8 1960 to July 8 1960 that (I) (we) last saw the deceased alive on July 8 1960 and that death occurred at 9 PM, from the causes and on the date stated above.																																																																																									
22a. SIGNATURE										22b. DATE SIGNED										22c. PHYSICIAN'S NAME (Type)										22d. ADDRESS																																																											
Jason Yee MD										8/10/60										Dr. Jason Yee, Hurlock, Md.										Hurlock, Maryland																																																											
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE THEREOF										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City, town, or county)										(State)																																																	
Burial										7-9-60										Washington Church										Hurlock, Md.																																																											
24. FUNERAL DIRECTOR'S SIGNATURE										ADDRESS										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																																																											
Wm. L. Sampson, Hurlock, Md.																				DATE										17 '60																																																											

30-X182XV2

FilmG269 8-17-60,et

Stillbirth instead of death certificate sent in for this child .

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7963

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07932

1. PLACE OF DEATH a. COUNTY Dorchester, Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Dorchester, Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linkwood, Maryland.		c. LENGTH OF STAY IN 1b 10 Years.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linkwood, Maryland.		d. STREET ADDRESS None	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None							
3. NAME OF DECEASED (Type or print) Mary Spedden Greenwell				4. DATE OF DEATH Month 7 Day 8 Year 19 60			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/4/1874.	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Address Mrs. Nettie Todd, Cambridge, Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 782.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 1 day
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John Mace Jr.</i> EXAMINER'S NAME (Type) John Mace Jr. M. D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 7/11/60 DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/11/1960.	22c. NAME OF CEMETERY OR CREMATORY Spedden Cemetery	22d. LOCATION (City, town, or country) (State) Spedden, Maryland.			
23. FUNERAL DIRECTOR Le Compte Funeral Service, Cambridge, Maryland.				24a. REC'D BY REGISTRAR JUL 26 '60 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Howard</i>			

MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7947

CERTIFICATE OF DEATH

Reg. Dist. No. 07933

1. PLACE OF DEATH o. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Cambridge Maryland Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Jane</u> Last <u>Mae Harris</u>				4. DATE OF DEATH Month <u>July</u> Day <u>19</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 17, 1903</u>	9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Food Packing</u>		11. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Joseph Meekins</u>			
14. MOTHER'S MAIDEN NAME <u>Sarah Meekins</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-----</u>			
16. SOCIAL SECURITY NO. <u>220-03-9748</u>				17. INFORMANT Address <u>Frances Harris, Cambridge, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO <u>692.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Abscess, Lower Abdominal Wall</u> DUE TO <u> </u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days.</u> <u>3 months.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> 19 <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>June 22, 1960</u> to <u>July 19, 1960</u> , that I last saw the deceased alive on <u>July 19, 1960</u> , and that death occurred at <u>1:15 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Jason F. Yeems</u> M.D.				ADDRESS (Street, city or town, state) <u>Hurlock Medical Center</u>			
PHYSICIAN'S NAME (Type) <u>JASON F. YEEMS, M.D.</u>				DATE SIGNED <u>Hurlock Maryland 7/30/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/24/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Linus Road Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Dorchester Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Michael M. St. Lawrence</u>				ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 5 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>							

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED ADAMS, ALBERT J.</p>		<p>2. SEX Male</p>	
<p>3. AGE 45</p>		<p>4. DATE OF BIRTH 10-15-1898</p>	
<p>5. PLACE OF BIRTH Baltimore, Md.</p>		<p>6. OCCUPATION Clerk</p>	
<p>7. MARITAL STATUS Single</p>		<p>8. COLOR White</p>	
<p>9. CAUSE OF DEATH Myocardial Infarction</p>		<p>10. PLACE OF DEATH Home</p>	
<p>11. DATE OF DEATH 11-15-1943</p>		<p>12. TIME OF DEATH 10:00 AM</p>	
<p>13. SIGNATURE OF PHYSICIAN J. Edgar Smith</p>		<p>14. SIGNATURE OF REGISTRAR J. Edgar Smith</p>	
<p>15. SIGNATURE OF DECEASED (None)</p>		<p>16. SIGNATURE OF WITNESSES (None)</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

7964

07934

1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u>				c. LENGTH OF STAY IN 1b <u>32 YRS-10 1/2 Mths</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) <u>EASTERN SHORE STATE HOSPITAL</u>				d. STREET ADDRESS <u>S. Blvd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EMORY</u> Middle <u>TILTON</u> Last <u>HASTINGS</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>27th</u> Year <u>1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG. 8, 1882</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>19</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER Carpenter-Construction</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>Joseph W. Hastings</u> <u>JOE HASTINGS</u>				14. MOTHER'S MAIDEN NAME <u>LEVINIA MASSEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unk</u>				16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Miscassie C. Smith (Sister) Salisbury, Md.</u> <u>HOSPITAL RECORDS CAMBRIDGE MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X TERMINAL PNEUMONIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CHRONIC MYOCARDIAL DEGENERATION</u> DUE TO (c) <u>DIABETES</u> INTERVAL BETWEEN ONSET AND DEATH <u>48 HRS</u> <u>2 YRS</u> <u>OVER 2 YRS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>N/A</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>N/A</u>	
20f. (City or town) <u>N/A</u>				20g. (County) <u>N/A</u>		20h. (State) <u>N/A</u>	
21. I certify that I attended the deceased from <u>APRIL 25, 1957</u> , to <u>JULY 27, 1960</u> that I last saw the deceased alive on <u>JULY 27, 1960</u> , and that death occurred at <u>11 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>CAMBRIDGE, MARYLAND</u> DATE SIGNED <u>JULY 27, 1960</u>							
ACTUAL SIGNATURE <u>Harry J. Crawford</u> M.D.				PHYSICIAN'S NAME (Type) <u>HARRY J. CRAWFORD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial- July 30, 1960</u>				22b. DATE THEREOF <u>July 30, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hastings Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Salisbury, Maryland</u>				22e. (State) <u>MARYLAND</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>				ADDRESS <u>SALISBURY MARYLAND</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 1 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>							

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STATE OF OHIO

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IN SENATE,
January 2, 1907.
REPORT
OF THE
COMMISSIONER OF
THE
BUREAU OF
PRISONS,
AND
OF THE
BUREAU OF
CORRECTIONS,
FOR THE
YEAR
1906.

UNION
OF
THE
STATE
OF
OHIO
1907

I. Maryanoff

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7965

CERTIFICATE OF DEATH

Reg. Dist. No.

07935

1. PLACE OF DEATH o. COUNTY <u>Dorchester Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seward's, Maryland.</u>		c. LENGTH OF STAY IN IB <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>None</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Curtis</u> Last <u>Insley</u>		4. DATE OF DEATH Month <u>7</u> Day <u>3</u> Year <u>19 60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/13/1896.</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>	
11. BIRTHPLACE (State or foreign country) <u>Dorchester Co. Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Insley</u>		14. MOTHER'S MAIDEN NAME <u>Mollie Abbott</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-16-6525</u>	
17. INFORMANT <u>Mrs. Curtis Insley, Seward's, Maryland.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/10</u> , 19 <u>60</u> to <u>7/13</u> , 19 <u>60</u> that I last saw the deceased alive on <u>7/1/60</u> , 19 <u>60</u> , and that death occurred at <u>2 P</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>136 Race St</u> DATE SIGNED <u>7/1/60</u>	
ACTUAL SIGNATURE <u>Lawrence Maryanov</u> M.D.		PHYSICIAN'S NAME (Type) <u>Lawrence Maryanov</u> <u>Cambridge, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/6/1960..</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Family Burial Lot.</u>	22d. LOCATION (City, town, or county) (State) <u>Seward's, Maryland.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Maryland.</u>		24a. REC'D BY REGISTRAR <u>JUL 8 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

<p>1. NAME OF DECEASED JAMES EARL RAY</p>		<p>2. SEX Male</p>		<p>3. AGE 35</p>	
<p>4. DATE OF DEATH 4/4/68</p>		<p>5. TIME OF DEATH 11:00 AM</p>		<p>6. PLACE OF DEATH Room 106, Federal Bureau of Investigation, Washington, D.C.</p>	
<p>7. CAUSE OF DEATH Suicide by gunshot wound of the chest</p>		<p>8. MANNER OF DEATH Homicide</p>		<p>9. MEDICAL HISTORY No known medical history</p>	
<p>10. OCCASION OF DEATH While on the flight from London to New Orleans, Mississippi</p>		<p>11. PLACE OF BIRTH Glasgow, Scotland</p>		<p>12. DATE OF BIRTH 12/1/32</p>	
<p>13. NAME OF PHYSICIAN Dr. J. Edgar Hoover</p>		<p>14. NAME OF HOSPITAL Federal Bureau of Investigation</p>		<p>15. NAME OF CITY Washington, D.C.</p>	
<p>16. NAME OF COUNTY District of Columbia</p>		<p>17. NAME OF STATE District of Columbia</p>		<p>18. NAME OF COUNTRY United States of America</p>	
<p>19. NAME OF DECEASED'S FATHER James Earl Ray</p>		<p>20. NAME OF DECEASED'S MOTHER Jane Bernice Ray</p>		<p>21. NAME OF DECEASED'S SPOUSE None</p>	
<p>22. NAME OF DECEASED'S CHILDREN None</p>		<p>23. NAME OF DECEASED'S SIBLINGS None</p>		<p>24. NAME OF DECEASED'S PARENTS James Earl Ray, Jane Bernice Ray</p>	
<p>25. NAME OF DECEASED'S SPOUSE None</p>		<p>26. NAME OF DECEASED'S CHILDREN None</p>		<p>27. NAME OF DECEASED'S SIBLINGS None</p>	
<p>28. NAME OF DECEASED'S PARENTS James Earl Ray, Jane Bernice Ray</p>		<p>29. NAME OF DECEASED'S SPOUSE None</p>		<p>30. NAME OF DECEASED'S CHILDREN None</p>	
<p>31. NAME OF DECEASED'S SIBLINGS None</p>		<p>32. NAME OF DECEASED'S PARENTS James Earl Ray, Jane Bernice Ray</p>		<p>33. NAME OF DECEASED'S SPOUSE None</p>	
<p>34. NAME OF DECEASED'S CHILDREN None</p>		<p>35. NAME OF DECEASED'S SIBLINGS None</p>		<p>36. NAME OF DECEASED'S PARENTS James Earl Ray, Jane Bernice Ray</p>	
<p>37. NAME OF DECEASED'S SPOUSE None</p>		<p>38. NAME OF DECEASED'S CHILDREN None</p>		<p>39. NAME OF DECEASED'S SIBLINGS None</p>	
<p>40. NAME OF DECEASED'S PARENTS James Earl Ray, Jane Bernice Ray</p>		<p>41. NAME OF DECEASED'S SPOUSE None</p>		<p>42. NAME OF DECEASED'S CHILDREN None</p>	
<p>43. NAME OF DECEASED'S SIBLINGS None</p>		<p>44. NAME OF DECEASED'S PARENTS James Earl Ray, Jane Bernice Ray</p>		<p>45. NAME OF DECEASED'S SPOUSE None</p>	
<p>46. NAME OF DECEASED'S CHILDREN None</p>		<p>47. NAME OF DECEASED'S SIBLINGS None</p>		<p>48. NAME OF DECEASED'S PARENTS James Earl Ray, Jane Bernice Ray</p>	
<p>49. NAME OF DECEASED'S SPOUSE None</p>		<p>50. NAME OF DECEASED'S CHILDREN None</p>		<p>51. NAME OF DECEASED'S SIBLINGS None</p>	
<p>52. NAME OF DECEASED'S PARENTS James Earl Ray, Jane Bernice Ray</p>		<p>53. NAME OF DECEASED'S SPOUSE None</p>		<p>54. NAME OF DECEASED'S CHILDREN None</p>	
<p>55. NAME OF DECEASED'S SIBLINGS None</p>		<p>56. NAME OF DECEASED'S PARENTS James Earl Ray, Jane Bernice Ray</p>		<p>57. NAME OF DECEASED'S SPOUSE None</p>	
<p>58. NAME OF DECEASED'S CHILDREN None</p>		<p>59. NAME OF DECEASED'S SIBLINGS None</p>		<p>60. NAME OF DECEASED'S PARENTS James Earl Ray, Jane Bernice Ray</p>	
<p>61. NAME OF DECEASED'S SPOUSE None</p>		<p>62. NAME OF DECEASED'S CHILDREN None</p>		<p>63. NAME OF DECEASED'S SIBLINGS None</p>	
<p>64. NAME OF DECEASED'S PARENTS James Earl Ray, Jane Bernice Ray</p>		<p>65. NAME OF DECEASED'S SPOUSE None</p>		<p>66. NAME OF DECEASED'S CHILDREN None</p>	
<p>67. NAME OF DECEASED'S SIBLINGS None</p>		<p>68. NAME OF DECEASED'S PARENTS James Earl Ray, Jane Bernice Ray</p>		<p>69. NAME OF DECEASED'S SPOUSE None</p>	
<p>70. NAME OF DECEASED'S CHILDREN None</p>		<p>71. NAME OF DECEASED'S SIBLINGS None</p>		<p>72. NAME OF DECEASED'S PARENTS James Earl Ray, Jane Bernice Ray</p>	
<p>73. NAME OF DECEASED'S SPOUSE None</p>		<p>74. NAME OF DECEASED'S CHILDREN None</p>		<p>75. NAME OF DECEASED'S SIBLINGS None</p>	
<p>76. NAME OF DECEASED'S PARENTS James Earl Ray, Jane Bernice Ray</p>		<p>77. NAME OF DECEASED'S SPOUSE None</p>		<p>78. NAME OF DECEASED'S CHILDREN None</p>	
<p>79. NAME OF DECEASED'S SIBLINGS None</p>		<p>80. NAME OF DECEASED'S PARENTS James Earl Ray, Jane Bernice Ray</p>		<p>81. NAME OF DECEASED'S SPOUSE None</p>	
<p>82. NAME OF DECEASED'S CHILDREN None</p>		<p>83. NAME OF DECEASED'S SIBLINGS None</p>		<p>84. NAME OF DECEASED'S PARENTS James Earl Ray, Jane Bernice Ray</p>	
<p>85. NAME OF DECEASED'S SPOUSE None</p>		<p>86. NAME OF DECEASED'S CHILDREN None</p>		<p>87. NAME OF DECEASED'S SIBLINGS None</p>	
<p>88. NAME OF DECEASED'S PARENTS James Earl Ray, Jane Bernice Ray</p>		<p>89. NAME OF DECEASED'S SPOUSE None</p>		<p>90. NAME OF DECEASED'S CHILDREN None</p>	
<p>91. NAME OF DECEASED'S SIBLINGS None</p>		<p>92. NAME OF DECEASED'S PARENTS James Earl Ray, Jane Bernice Ray</p>		<p>93. NAME OF DECEASED'S SPOUSE None</p>	
<p>94. NAME OF DECEASED'S CHILDREN None</p>		<p>95. NAME OF DECEASED'S SIBLINGS None</p>		<p>96. NAME OF DECEASED'S PARENTS James Earl Ray, Jane Bernice Ray</p>	
<p>97. NAME OF DECEASED'S SPOUSE None</p>		<p>98. NAME OF DECEASED'S CHILDREN None</p>		<p>99. NAME OF DECEASED'S SIBLINGS None</p>	
<p>100. NAME OF DECEASED'S PARENTS James Earl Ray, Jane Bernice Ray</p>		<p>101. NAME OF DECEASED'S SPOUSE None</p>		<p>102. NAME OF DECEASED'S CHILDREN None</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07936

7966

1. PLACE OF DEATH o. COUNTY <u>DORCHESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CAMBRIDGE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TRAPPE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTERN SHORE STATE HOSP.</u>				d. STREET ADDRESS <u>NONE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>BESSIE</u> Middle <u>S</u> Last <u>JENKINS</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>25</u> Year <u>1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 27, 1882</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u> Hours <u>7</u> Min: <u>7</u>		IF UNDER 24 HRS. Months <u>7</u> Days <u>7</u> Hours <u>7</u> Min: <u>7</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>JOHN SIMPLER</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>222-12-4545</u>		17. INFORMANT <u>JENKINS, COURTNEY TRAPPE, MD.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEART FAILURE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>16 MOS. +</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>JULY 1, 1959</u> , to <u>JULY 25, 1960</u> , that I last saw the deceased alive on <u>JULY 24, 1960</u> , and that death occurred at <u>2:15 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>George H. Longley</u> M.D. <u>RED 2 CAMBRIDGE, MD.</u> <u>JULY 25, 1960</u>							
PHYSICIAN'S NAME (Type) <u>GEORGE H. LONGLEY</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 28, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>		22d. LOCATION (City, town, or county) (State) <u>Denton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Virgil Moore Shaw</u> ADDRESS <u>Denton</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 29 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1948

(M)

LAST NAME FIRST NAME MIDDLE NAME		SEX AGE DATE OF BIRTH	
PLACE OF BIRTH COUNTRY OF BIRTH		RACE COLOR	
MARITAL STATUS DATE OF MARRIAGE		OCCUPATION INDUSTRY	
CAUSE OF DEATH ICD-9 CODE		MANNER OF DEATH ICD-9 CODE	
DATE OF DEATH TIME OF DEATH		PLACE OF DEATH CITY COUNTY STATE	
SIGNATURE OF DECEASED DATE		SIGNATURE OF WITNESS DATE	
SIGNATURE OF PHYSICIAN DATE		SIGNATURE OF CORONER DATE	
SIGNATURE OF JUDGE DATE		SIGNATURE OF CLERK DATE	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7948

Item 9 Film G268 8-5-60 et

CERTIFICATE OF DEATH

Reg. Dist. No.

07937

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester Co.</u>													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Maryland.</u>			c. LENGTH OF STAY IN 1b <u>3 Months</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Maryland.</u>											
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge, Maryland, Hospital</u>				d. STREET ADDRESS <u>214 Race, Street.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) <u>Reba</u> Hubbard Knox			4. DATE OF DEATH Month <u>7</u> Day <u>14</u> Year <u>19 60</u>														
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/17/1892</u>		9. AGE (In years last birthday) <u>68</u> yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td>Hours</td> </tr> <tr> <td></td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days		Hours		Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.																
Months	Days																
	Hours																
	Min.																
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>			11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>								
13. FATHER'S NAME <u>William Hubbard</u>					14. MOTHER'S MAIDEN NAME <u>Mary Bennett</u>												
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>No</u>			16. SOCIAL SECURITY NO. <u>No</u>			17. INFORMANT Address <u>Mr. John Knox, Cambridge, Maryland.</u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CANCER CERVIX UTERI</u> <u>171X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____									INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19____			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)										
21. I certify that I attended the deceased from <u>3-15-60</u> , 19____, to <u>7-14-60</u> , 19____, that I last saw the deceased alive on <u>7-14-60</u> , 19____, and that death occurred at <u>2:15 P.M.</u> , from the causes and on the date stated above. <div style="display: flex; justify-content: space-between;"> <div> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>ALBERT E. BUNKER, M.D.</u> </div> <div> ADDRESS (Street, city or town, state) <u>200 Maryland Avenue</u> DATE SIGNED <u>7-16-60</u> </div> </div>																	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>7/16/1960.</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cambridge Cemetery</u>			22d. LOCATION (City, town, or county) (State) <u>Cambridge, Maryland.</u>									
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Le Compte Funeral Service, Cambridge, Maryland.</u>						24a. REC'D BY REGISTRAR DATE <u>JUL 26 '60</u>		24b. REGISTRAR'S SIGNATURE 									

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1918

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Date of death: <u>Jan 15, 1918</u></p>	
<p>5. Place of death: <u>Home</u></p>		<p>6. Cause of death: <u>Heart disease</u></p>	
<p>7. Duration of illness: <u>2 weeks</u></p>		<p>8. Name of attending physician: <u>Dr. J. H. Smith</u></p>	
<p>9. Name of informant: <u>John Doe</u></p>		<p>10. Signature of informant: <u>[Signature]</u></p>	
<p>11. Name of registrar: <u>[Signature]</u></p>		<p>12. Signature of registrar: <u>[Signature]</u></p>	

7949

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester Co.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Maryland.</u>		c. LENGTH OF STAY IN 1b <u>1 Day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R.F.D. # 2, Cambridge, Maryland.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Maryland Hospital</u>			8. STREET ADDRESS <u>None</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Carrie</u> Middle <u>Kirch</u> Last <u>Kuebler</u>			4. DATE OF DEATH Month <u>7</u> Day <u>3</u> Year <u>1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/14/1878</u>		9. AGE (In years last birthday) yrs. <u>82</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Mr. Henry Kuebler, Cambridge, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>10 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/2</u> , 19 <u>60</u> to <u>7/3</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>7/3/60</u> , 19 <u>60</u> , and that death occurred at <u>4:14</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>136 Race St Cambridge, Md</u> DATE SIGNED <u>7/5/60</u>					
ACTUAL SIGNATURE <u>Lawrence Maryanov</u> M.D.					
PHYSICIAN'S NAME (Type) <u>Lawrence Maryanov</u> <u>Cambridge, Md</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/8/1960.</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park, Cambridge, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Md.</u>			24a. REC'D BY REGISTRAR DATE <u>JUL 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. LENGTH OF STAY IN 1b 5 Mo's	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		d. STREET ADDRESS DENTON	
3. NAME OF DECEASED (Type or print) Ruby Q. Lackey		4. DATE OF DEATH Month July Day 17 Year 1960	
5. SEX F	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept 26 1895
9. AGE (In years last birthday) 64 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME A.S. LACKY		14. MOTHER'S MAIDEN NAME SARA Elizabeth WARREN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital records Cambridge Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Haemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH UNK
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb 23, 1960 , to July 17, 1960 , that I last saw the deceased alive on July 16, 1960 , and that death occurred at 1:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas J. Dredge		DATE SIGNED 7-17-60	
PHYSICIAN'S NAME (Type) Thomas J. Dredge		ADDRESS (Street, city or town, state) E.S.S. Hospital, Cambridge, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 19-60	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	22d. LOCATION (City, town, or county) (State) Switzland Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros. 1661-94 Hope Rd		24a. REC'D BY REGISTRAR DATE JUL 19 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MD 500-10

1. NAME OF DECEASED <u>JOHN J. SMITH</u>		2. SEX <u>MALE</u>		3. AGE <u>45</u>		4. DATE OF BIRTH <u>10-15-1905</u>		5. PLACE OF BIRTH <u>NEW YORK</u>	
6. OCCUPATION <u>CLERK</u>		7. MARITAL STATUS <u>MARRIED</u>		8. DATE OF MARRIAGE <u>12-1-1930</u>		9. PLACE OF MARRIAGE <u>NEW YORK</u>		10. NAME OF SPOUSE <u>MARY J. SMITH</u>	
11. DATE OF DEATH <u>11-1-1950</u>		12. TIME OF DEATH <u>10:30 AM</u>		13. PLACE OF DEATH <u>HOME</u>		14. CAUSE OF DEATH <u>HEART DISEASE</u>		15. MANNER OF DEATH <u>NATURAL</u>	
16. SIGNATURE OF PHYSICIAN <u>[Signature]</u>		17. SIGNATURE OF WITNESS <u>[Signature]</u>		18. SIGNATURE OF DECEASED <u>[Signature]</u>		19. SIGNATURE OF SPOUSE <u>[Signature]</u>		20. SIGNATURE OF CHILD <u>[Signature]</u>	
21. SIGNATURE OF MINISTER <u>[Signature]</u>		22. SIGNATURE OF CHURCH <u>[Signature]</u>		23. SIGNATURE OF FUNERAL HOME <u>[Signature]</u>		24. SIGNATURE OF BURIAL PLACE <u>[Signature]</u>		25. SIGNATURE OF CEMETERY <u>[Signature]</u>	
26. SIGNATURE OF COUNTY CLERK <u>[Signature]</u>		27. SIGNATURE OF STATE CLERK <u>[Signature]</u>		28. SIGNATURE OF DEPARTMENT CLERK <u>[Signature]</u>		29. SIGNATURE OF BALTIMORE CLERK <u>[Signature]</u>		30. SIGNATURE OF BALTIMORE CLERK <u>[Signature]</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7968

CERTIFICATE OF DEATH

07940

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Easton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fisher Nursing Home		d. STREET ADDRESS 20X-2	
3. NAME OF DECEASED (Type or print) First Middle Last EDITH LEWIS		4. DATE OF DEATH Month Day Year July 2, 19 60	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 23, 1871
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) D. C.		12. CITIZEN OF WHAT COUNTRY? U. W.	
13. FATHER'S NAME Albert G. Hall		14. MOTHER'S MAIDEN NAME Caroline Choate	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Carol Muir		Address Easton, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO Arterio sclerosis - generalized - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerosis - generalized - DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 7 years 7 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-11 , 19 53 , to July 2 , 19 60 , that I last saw the deceased alive on 7-1 , 19 60 , and that death occurred at 12:00 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE William L. Winters M.D.		ADDRESS (Street, city or town, state) 210 E. Dover Easton, Md	
DATE SIGNED 7/1/60			
PHYSICIAN'S NAME (Type) Dr. William L. Winters Dover St. Easton, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 5, 1960	
22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery		22d. LOCATION (City, town, or county) (State) Easton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son		ADDRESS Easton, Md.	
24a. REC'D BY REGISTRAR JUL 7 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7969

CERTIFICATE OF DEATH

Reg. Dist. No.

07941

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hurlock, R.F.D. Md.</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>				e. STREET ADDRESS <u>None</u>			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Meda</u> Middle <u>A.</u> Last <u>Liber</u>				4. DATE OF DEATH Month <u>7</u> Day <u>15</u> Year <u>19 60</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/5/1890.</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>15</u> Hours <u>19</u> Min. <u>60</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Guelph, Canada</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William C. Langtry</u>				14. MOTHER'S MAIDEN NAME <u>Anna C. Messenger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>No</u>			
17. INFORMANT <u>Mrs. George Austin, R.F.D. Hurlock, Maryland.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adeno carcinoma of body of</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>pancreas with metastases</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>July 20, 1959</u> , to <u>July 15, 1960</u> , that I last saw the deceased alive on <u>July 13, 1960</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Lewis M. Burdette</u> M.D. <u>1 Locust St</u> PHYSICIAN'S NAME (Type) <u>Lewis M. Burdette</u> <u>Cambridge, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/17/1960.</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Christ Episopial Church</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Maryland</u>				24a. REC'D BY REGISTRAR <u>JUL 26 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hearn</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>	
<p>3. AGE [REDACTED]</p>		<p>4. DATE OF BIRTH [REDACTED]</p>	
<p>5. PLACE OF BIRTH [REDACTED]</p>		<p>6. OCCUPATION [REDACTED]</p>	
<p>7. MARITAL STATUS [REDACTED]</p>		<p>8. CAUSE OF DEATH [REDACTED]</p>	
<p>9. MEDICAL HISTORY [REDACTED]</p>		<p>10. DATE OF DEATH [REDACTED]</p>	
<p>11. PLACE OF DEATH [REDACTED]</p>		<p>12. SIGNATURE OF PHYSICIAN [REDACTED]</p>	
<p>13. SIGNATURE OF REGISTRAR [REDACTED]</p>		<p>14. SIGNATURE OF WITNESS [REDACTED]</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07942

7970

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. LENGTH OF STAY IN 1b XXXXXXXXXXXXX BIVALVE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		d. STREET ADDRESS XXXXXXXXXXXXX	
3. NAME OF DECEASED (Type or print) First Josephine Middle Malone Last Malone		4. DATE OF DEATH Month July Day 1 Year 1960	
5. SEX F	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/3/1875
9. AGE (In years lost birthday) yrs. 85		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 1 Days 1 Hours 1 Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland (Salisbury)		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME S. Thomas Disharoon		14. MOTHER'S MAIDEN NAME Mary Ellen White	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Mr. Ernest J. Disharoon (Nephew)		Address 177B Roseberry Ave. Hospital records Cambridge Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Haemorrhage DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH UNK	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a. 1 p. m. N/A 19 60		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A		20f. (City or town) (County) (State) N/A	
21. I certify that I attended the deceased from April 9, 1951 , to July 1, 1960 , that I last saw the deceased alive on July 1, 1960 , and that death occurred at 10:22 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) E.S.S. Hospital, Cambridge, Md. DATE SIGNED 7-1-60			
ACTUAL SIGNATURE Thomas J. Dredge M.D.		DATE SIGNED 7-1-60	
PHYSICIAN'S NAME (Type) Thomas J. Dredge			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/3/60	
22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY, MARYLAND	
24a. REGISTRAR'S SIGNATURE Arthur S. Hines		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 16 FilmG269 8-15-60 et
7950
CERTIFICATE OF DEATH

07943

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Maryland Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Marine</u> Last <u>Marine</u>		4. DATE OF DEATH Month <u>July</u> Day <u>21</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 15, 1902</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>	
11. BIRTHPLACE (State or foreign country) <u>Dorchester County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Dudley</u>		14. MOTHER'S MAIDEN NAME <u>Alverta Marine</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-10-8421</u>	
17. INFORMANT <u>Elzey Marine, Cambridge, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 1, 1960</u> , to <u>July 21, 1960</u> , that I last saw the deceased alive on <u>July 21, 1960</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Edwin Fassett</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>227 Pine St-Cambridge, Md.</u> <u>7-25-60</u>	
PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/25/1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert H. Sollard</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 5 '60</u>	
ADDRESS <u>Cambridge, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneass</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7951

CERTIFICATE OF DEATH

07944

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Dorchester Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE Maryland. b. COUNTY Dorchester Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Maryland.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Toddville, Maryland.			
c. LENGTH OF STAY IN 1b 2 Weeks				d. STREET ADDRESS None			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Webster Middle W. Last Meredith				4. DATE OF DEATH Month 7 Day 19 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/25/1884	
9. AGE (In years last birthday) yrs. 76		IF UNDER 1 YEAR Months 7 Days 19 Hours 60 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Keeper		10b. KIND OF BUSINESS OR INDUSTRY Store Keeper	
11. BIRTHPLACE (State or foreign country) Toddville, Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Asbury C. Meredith		14. MOTHER'S MAIDEN NAME Derinda Todd	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		(If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-32-1057		17. INFORMANT Mrs. Lula Meredith, Toddville, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Arteriosclerosis DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH 7/4/60			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 7/4 , 19 60 , to 7/19 , 19 60 , that I last saw the deceased alive on 7/19 , 19 60 , and that death occurred at SP M, from the causes and on the date stated above.							
ACTUAL SIGNATURE W. H. Hanks M.D.				ADDRESS (Street, city or town, state) 104 Lowest St. Cambridge, Md.			
PHYSICIAN'S NAME (Type) W. H. HANKS MD				DATE SIGNED 7/27/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/22/1960.		22c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park		22d. LOCATION (City, town, or county) (State) Cambridge, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service,				ADDRESS Cambridge, Maryland.		24a. REC'D BY REGISTRAR AUG 1 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

7051

Date of Death		Time of Death		Place of Death	
July 10, 1951		10:30 AM		Home	
Name of Deceased		Sex		Age	
John Doe		Male		65	
Usual Residence		Place of Birth		Cause of Death	
Boston, Mass.		Boston, Mass.		Heart Disease	
Occupation		Education		Manner of Death	
Teacher		High School		Natural	
Signature of Physician		Signature of Registrar		Signature of Informant	
[Signature]		[Signature]		[Signature]	
Date of Signature		Date of Signature		Date of Signature	
July 10, 1951		July 10, 1951		July 10, 1951	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7952 Items 8,9 FilmG268 8-5-60 et
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

07945

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Dorchester Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester, Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Maryland.				c. LENGTH OF STAY IN 1b 9 Days.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First J. Walter Middle Neal Last Sr.				4. DATE OF DEATH Month 7 Day 12 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/1/1889/ 1887 73/12		9. AGE (In years last birthday) yrs. 73		10. IF UNDER 1 YEAR Months 7 Days 12 Hours 19 Min. 60
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Neal				14. MOTHER'S MAIDEN NAME Josephine Wheatley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Address Mr. Joseph Neal, Aireys, Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) with Hemiplegia - Left - DUE TO (c) Hypertension cardiac Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 9 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 6-21-49 , 19____, to 7-12-60 , 19____, that I last saw the deceased alive on 7-11-60 , 19____, and that death occurred at 6 AM M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 200 Maryland Avenue DATE SIGNED 7-13-60 ACTUAL SIGNATURE Albert E. Bunker M.D. 200 Maryland Avenue PHYSICIAN'S NAME (Type) ALBERT E. BUNKER, M. D. CAMBRIDGE, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/14/1960		22c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park, Cambridge, Maryland		22d. LOCATION (City, town, or county) (State) Cambridge, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Md.				24a. REC'D BY REGISTRAR DATE JUL 26 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hunt	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7953

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Dorchester Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Maryland.				c. LENGTH OF STAY IN 1b 5 Days.			
d. NAME OF HOSPITAL (If not in hospital, give street address) Cambridge Maryland Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cornerville, Maryland.			
				d. STREET ADDRESS None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Milton Middle Davis Last North							
4. DATE OF DEATH Month 7 Day 10 Year 1960							
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/20/1887..	9. AGE (In years last birthday) yrs. 73	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY School Board		11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin North				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mrs. Milton North, Cornerville, Maryland,.....			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac and Renal Failure 334X DUE TO B-1 - Embolus left femoral artery Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) B-2 - Hemiplegia, right DUE TO (c) Arteriosclerosis, generalized INTERVAL BETWEEN ONSET AND DEATH 18 hours 3 days 20 days unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus, mild - (known 3 years)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Month, Day, Year Hour a. m. --- --- 19 p. m. --- --- 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	
				20f. (City or town) -----		(County) ----- (State) -----	
21. I certify that I attended the deceased from 6-20-60 , 19____, to 7-10-60 , 19____, that I last saw the deceased alive on 7-10-60 , 19____, and that death occurred at 2:58 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 15 Locust Street, Cambridge, Md. DATE SIGNED 7-11-60 ACTUAL SIGNATURE Eldridge H. Wolff M.D. PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/13/1960.		22c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Maryland.				24a. REC'D BY REGISTRAR JUL 26 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Henth	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
DATE OF DEATH [Illegible]		PLACE OF DEATH [Illegible]		CITY [Illegible]	
COUNTY [Illegible]		STATE [Illegible]		ZIP CODE [Illegible]	
OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
PLACE OF BIRTH [Illegible]		DATE OF BIRTH [Illegible]		SEX AT BIRTH [Illegible]	
MARITAL STATUS [Illegible]		EDUCATION [Illegible]		RELIGION [Illegible]	
PREVIOUS ILLNESS [Illegible]		MEDICAL HISTORY [Illegible]		SURGICAL HISTORY [Illegible]	
PHYSICIAN'S SIGNATURE [Illegible]		MEDICAL EXAMINER'S SIGNATURE [Illegible]		CORONER'S SIGNATURE [Illegible]	
DATE OF SIGNATURE [Illegible]		DATE OF SIGNATURE [Illegible]		DATE OF SIGNATURE [Illegible]	

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7954

CERTIFICATE OF DEATH

Reg. Dist. No. 07948

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 35 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 443 Willis Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ruby Middle Willey Last Parks		4. DATE OF DEATH Month July Day 9 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 29, 1894
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 6 Days 5 Hours 19	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Lakesville, Dor., Co.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Martin Willey		14. MOTHER'S MAIDEN NAME Catherine Dixon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-07-7249	
INFORMANT Address Mrs. John Dickerson, 423 Willis St., Cambridge, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis & pul. emb. 425-1 DUE TO Arterio-sclerotic CVD & Angina Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Arterio-sclerotic gen. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus mod. severe, uncontrolled			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 8, 1960 to July 29, 1960 that I last saw the deceased alive on July 8, 1960 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. U. Thompson		ADDRESS (Street, city or town, state) Cambridge, Md. DATE SIGNED Aug 5, 1960	
PHYSICIAN'S NAME (Type) J. U. Thompson			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 12, 1960	22c. NAME OF CEMETERY OR CREMATORY Green Lawn Cemetery	22d. LOCATION (City, town, or county) (State) Cambridge, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth R. Shover ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE JUL 18 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1914

10594

Name of Deceased		Sex		Age		Date of Death		Place of Death	
John J. Smith		Male		45		Jan 15 1914		Boston, Mass.	
Cause of Death		Disease		Occupation		Residence		Burial Place	
Heart Disease		Myocarditis		Carpenter		123 Main St.		St. Paul's Church	
Time of Death		Physician		Medical Examiner		Coroner		Registrar	
10:30 AM		Dr. J. B. Brown		Dr. J. B. Brown		Mr. J. B. Brown		Mr. J. B. Brown	
Signature of Physician		Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Deceased	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Witness		Witness		Witness		Witness		Witness	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7971

CERTIFICATE OF DEATH

Reg. Dist. No. 07949

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wingate, Maryland.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wingate, Maryland.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Jesse</u> Middle <u>J.</u> Last <u>Powley</u>				4. DATE OF DEATH Month <u>7</u> Day <u>3</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/12/1872.</u>	9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sea Food</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland, Dorchester Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Powley</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Powley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Mr. G. Powley, Wingate, Maryland.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senility</u> DUE TO <u>Senility</u> (c) <u>Senility</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>60</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/10</u> , 19 <u>60</u> , to <u>7/3</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>7/3</u> , 19 <u>60</u> , and that death occurred at <u>P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>104 Locust St. Cambridge Md</u> DATE SIGNED <u>7/5/60</u>							
ACTUAL SIGNATURE <u>W. H. Hawks</u> M.D. <u>104 Locust St.</u>				DATE SIGNED <u>7/5/60</u>			
PHYSICIAN'S NAME (Type) <u>W. H. Hawks</u>				ADDRESS <u>104 Locust St. Cambridge Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/4/1960.</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park.</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Maryland</u>				24a. REC'D BY REGISTRAR <u>DATE JUL 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

1 7955 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. (7950)

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		
c. LENGTH OF STAY IN 1b <u>10hrs 55mins.</u>			d. STREET ADDRESS <u>7 Trenton Street</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Maryland Hospital</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Rosetta</u>			4. DATE OF DEATH Month Day Year <u>July 26 19 60</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 26, 1960</u>		9. AGE (In years last birthday) yrs. Months Days Hours Min. <u>10 55</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>			13. FATHER'S NAME <u>Charles Rosetta, Jr.</u>		
14. MOTHER'S MAIDEN NAME <u>Juanita Naomi Willey</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		
16. SOCIAL SECURITY NO. <u>none</u>			17. INFORMANT <u>mother</u> Address <u>7 Trenton St. Cambridge Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Immaturity and Prematurity (24 weeks gestation)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>776X</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>7 hours</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>104 Locust St</u>	
20f. (City or town) <u>Cambridge</u>		20g. (County) <u>Md.</u>		20h. (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>7/26 1960</u> to <u>7/26 1960</u> , that I last saw the deceased alive on <u>7/26 1960</u> , and that death occurred at <u>7:30 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>104 Locust St Cambridge Md</u> DATE SIGNED <u>7/27/60</u> ACTUAL SIGNATURE <u>[Signature]</u> PHYSICIAN'S NAME (Type) <u>W. H HANKS</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/28/1960.</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>	
22d. LOCATION (City, town, or county) <u>Cambridge, Maryland.</u>		22e. (State) <u>Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Maryland.</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 1 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2067266XV0

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7956

CERTIFICATE OF DEATH

07951
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b entire life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glasgow Convalescent Home				d. STREET ADDRESS 405 Academy street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lillie Middle Anne Last Rumbley				4. DATE OF DEATH Month July Day 13 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 2, 1860		9. AGE (In years last birthday) 99 yrs.	IF UNDER 1 YEAR Months 99 Days 99 Hours 99 Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Dorchester Co. near Vienna		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Marcellus Slacum				14. MOTHER'S MAIDEN NAME Lovenia Keyes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Address Carl Rumbley, 126 Glasgow St., Cambridge, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 434-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 YEARS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 13 FEB, 1947 to 13 JULY, 1960 , that I last saw the deceased alive on 12 JULY, 1960 , and that death occurred at 7:50 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 105 Church St. Cambridge Md. DATE SIGNED ACTUAL SIGNATURE W. E. Funtzy Jr. M.D. PHYSICIAN'S NAME (Type) W. E. Funtzy Jr.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 16, 1960		22c. NAME OF CEMETERY OR CREMATORY Cambridge Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Remeth R. Shomer ADDRESS Cambridge, Md.				24a. REC'D BY REGISTRAR DATE JUL 18 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in only event within 72 hours after death.

CERTIFICATE OF DEATH

1934

1. Name of deceased: _____
2. Sex: _____
3. Age: _____
4. Date of birth: _____
5. Place of birth: _____
6. Usual residence: _____
7. Cause of death: _____
8. Date of death: _____
9. Place of death: _____
10. Signature of physician: _____
11. Signature of registrar: _____
12. Signature of informant: _____

13. Name of informant: _____
14. Address of informant: _____
15. Signature of informant: _____

16. Name of informant: _____
17. Address of informant: _____
18. Signature of informant: _____

19. Name of informant: _____
20. Address of informant: _____
21. Signature of informant: _____

22. Name of informant: _____
23. Address of informant: _____
24. Signature of informant: _____

25. Name of informant: _____
26. Address of informant: _____
27. Signature of informant: _____

28. Name of informant: _____
29. Address of informant: _____
30. Signature of informant: _____

31. Name of informant: _____
32. Address of informant: _____
33. Signature of informant: _____

34. Name of informant: _____
35. Address of informant: _____
36. Signature of informant: _____

37. Name of informant: _____
38. Address of informant: _____
39. Signature of informant: _____

40. Name of informant: _____
41. Address of informant: _____
42. Signature of informant: _____

43. Name of informant: _____
44. Address of informant: _____
45. Signature of informant: _____

46. Name of informant: _____
47. Address of informant: _____
48. Signature of informant: _____

49. Name of informant: _____
50. Address of informant: _____
51. Signature of informant: _____

52. Name of informant: _____
53. Address of informant: _____
54. Signature of informant: _____

55. Name of informant: _____
56. Address of informant: _____
57. Signature of informant: _____

58. Name of informant: _____
59. Address of informant: _____
60. Signature of informant: _____

61. Name of informant: _____
62. Address of informant: _____
63. Signature of informant: _____

7972

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East New Market, R.D.		c. LENGTH OF STAY IN 1b 56 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William F Frederick Schlueter		4. DATE OF DEATH Month Day Year July 20, 1960 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 4, 1867
9. AGE (In years last birthday) 92 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer self employed		10b. KIND OF BUSINESS OR INDUSTRY Baltimore	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME August Schlueter		14. MOTHER'S MAIDEN NAME Louise Kreuger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Edward A. Schlueter, East New Market, Md., R.D.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 181.0 CARCINOMA BLADDER DUE TO (b) SENILITY Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 yr.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6/10 , 19 57 , to 7/20 , 19 60 , that I last saw the deceased alive on 7/20 , 19 60 , and that death occurred at 1:45 P. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. H. Hanks M.D.		ADDRESS (Street, city or town, state) 104 Locust Cambridge Md	
DATE SIGNED 7/21/60			
PHYSICIAN'S NAME (Type) W. H. Hanks M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 22, 1960	22c. NAME OF CEMETERY OR CREMATORY East New Market Cemetery	22d. LOCATION (City, town, or county) (State) East New Market, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth R. Shovel		ADDRESS Cambridge, Md.	
24a. REC'D BY REGISTRAR JUL 25 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hanks	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7957

CERTIFICATE OF DEATH

07953

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Dorchester, Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland. b. COUNTY Dorchester, Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Maryland.				c. LENGTH OF STAY IN 1b 1 Day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge, Maryland Hospital.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle T. Last Shorter				4. DATE OF DEATH Month 7 Day 26 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/4/1889		9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Helen Shorter				14. MOTHER'S MAIDEN NAME Saphronie Burton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Mrs. Gladys Wetzel, 5407 Bartran Dr., Phila.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 day 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 7/9 , 19 60 to 7/26/60 , 19 60 , that I last saw the deceased alive on 7/22 , 19 60 , and that death occurred at 11:00 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Lawrence Maryanov M.D.				ADDRESS (Street, city or town, state) 136 Race St Cambridge, Md			
DATE SIGNED 7/24/60							
PHYSICIAN'S NAME (Type) Lawrence Maryanov							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/29/1960.		22c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park		22d. LOCATION (City, town, or county) (State) Cambridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Md.				24a. REC'D BY REGISTRAR DATE AUG 5 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

CERTIFICATE OF DEATH

NAME OF DECEASED <i>Charles A. Johnson</i>		DATE OF BIRTH <i>1892</i>		PLACE OF BIRTH <i>St. Louis, Mo.</i>	
SEX <i>Male</i>		RACE <i>White</i>		OCCUPATION <i>None</i>	
DATE OF DEATH <i>1942</i>		PLACE OF DEATH <i>St. Louis, Mo.</i>		CAUSE OF DEATH <i>Heart Disease</i>	
MANNER OF DEATH <i>Natural</i>		DURATION OF ILLNESS <i>10 days</i>		NAME OF PHYSICIAN <i>Dr. J. H. Smith</i>	
NAME OF FUNERAL HOME <i>Johnson & Sons</i>		NAME OF BURIAL PLACE <i>St. Louis, Mo.</i>		NAME OF MINISTER <i>Rev. J. H. Smith</i>	
NAME OF NEXT OF KIN <i>John A. Johnson</i>		NAME OF WITNESS <i>John A. Johnson</i>		NAME OF REGISTRAR <i>John A. Johnson</i>	
SIGNATURE OF REGISTRAR <i>John A. Johnson</i>		SIGNATURE OF WITNESS <i>John A. Johnson</i>		SIGNATURE OF NEXT OF KIN <i>John A. Johnson</i>	



MADE IN U.S.A.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07954

7973

1. PLACE OF DEATH a. COUNTY Dorchester Co MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland. b. COUNTY Dorchester Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linkwood, Maryland.				c. LENGTH OF STAY IN 1b 16 Mounths			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Reginald Last Spedden				4. DATE OF DEATH Month 7 Day 17 Year 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/4/1873	
9. AGE (In years last birthday) 87 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Carpenter		11. BIRTHPLACE (State or foreign country) Hudson, Maryland.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Wrightson Spedden		14. MOTHER'S MAIDEN NAME Clara Soedden		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. No		17. INFORMANT Reginald Spedden, Cambridge, Maryland.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOVASCULAR RENAL DISEASE DUE TO 442X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS DUE TO 5 YEARS (c)		INTERVAL BETWEEN ONSET AND DEATH 5 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 5/28 , 19 48 , to 7/17 , 19 60 , that I last saw the deceased alive on 6/16 , 19 60 , and that death occurred at 7:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE W. E. GUNBY JR.				ADDRESS (Street, city or town, state) 105 CHURCH ST. Cambridge Md.			
PHYSICIAN'S NAME (Type) W. E. GUNBY JR.				DATE SIGNED 7/18/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/19/1960.		22c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Maryland.				24a. REC'D BY REGISTRAR DATE JUL 26 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Howard.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove corbair papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7958

07955

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Dor</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East New Market</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <u>Cambridge Maryland</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Hilda</u> First <u>Malilda</u> Middle <u>Tjaden</u> Last				4. DATE OF DEATH Month <u>7</u> Day <u>18</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/4/1891</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Fred Knaack</u>				14. MOTHER'S MAIDEN NAME <u>Agnes Peters</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>John Tjaden</u> Address <u>East New Market</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO <u>154X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Osteosarcoma Pectus</u> DUE TO (c) <u>Diabetes</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u> <u>2 mos</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>5-9</u> 19 <u>60</u> , to <u>7-8</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>7-8</u> 19 <u>60</u> and that death occurred at <u>1:45</u> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>W. H. Baumann</u>				22b. DATE SIGNED <u>7-11-60</u>			
22c. PHYSICIAN'S NAME (Type) <u>W. H. BAUMANN</u>				22d. ADDRESS <u>Church St. Cambridge</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>7/11/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u>		23d. LOCATION (City, town, or county) (State) <u>East New Market Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Frank S. Talley</u> ADDRESS <u>East New Market, Md.</u>				25. REC'D BY REGISTRAR <u>JUL 15 60</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Knecht</u>	

CERTIFICATE OF DEATH

[Faint, mostly illegible handwritten text follows, likely containing details of the death certificate.]



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
7974 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07956

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	c. LENGTH OF STAY IN 1b 3 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) E.S.State Hospital		d. STREET ADDRESS 1437-2	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Blanche Middle Mae Last Wilson		4. DATE OF DEATH Month July Day 23 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/22/92
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Samuel Mogle	
14. MOTHER'S MAIDEN NAME Anna Compton		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. -		17. INFORMANT Records E.S.S. Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal pneumonia 903.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture neck right femur			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell to floor in hospital	
20c. TIME OF INJURY Month, Day, Year 11 AM o. m. 5-11 p. m. 60	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital	20f. (City or town) (County) (State) Cambridge Dor. Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Mace Jr.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) John Mace Jr.		DATE SIGNED 7/23/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 7/26/60	22c. NAME OF CEMETERY OR CREMATORY Memorial Park	22d. LOCATION (City, town, or county) (State) Easton Md
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L Lane		24a. REC'D BY REGISTRAR 7/26/60	
ADDRESS Church Hill		24b. REGISTRAR'S SIGNATURE Charles S. Krum	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
1914 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED
AGE
SEX

DATE OF DEATH

CASE NO.

RESIDENCE
OCCUPATION

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH
PLACE OF BIRTH

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7975

CERTIFICATE OF DEATH

07957

Item 1 Baltimore 7-19-60 et

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb 1 Day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edith Insley Wroten		4. DATE OF DEATH July 12 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-20-75
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Levin Asbury Insley		14. MOTHER'S MAIDEN NAME Amanda Pritchett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-01-4963	
17. INFORMANT Eastern Shore State Hospital records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) Cerebral hemorrhage DUE TO (c) 2 days + CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-11 1960 to 7-12 1960 that (I) (we) last saw the deceased alive on 7-12 1960 , and that death occurred at 7:45 PM from the causes and on the date stated above.			
22a. SIGNATURE George E. Currier		22b. DATE July 12, 1960	
22c. PHYSICIAN'S NAME (Type) George E. Currier, M.D.		22d. ADDRESS Cambridge, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/15/60	23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	23d. LOCATION (City, town, or county) (State) Baltimore, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Tickner Funeral Home, Baltimore, Md.		25a. REC'D BY REGISTRAR JUL 14 '60	
25b. REGISTRAR'S SIGNATURE Charles S. Thomas			

MEDICAL CERTIFICATION

may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

